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ABSTRACT

This paper discusses the results of a study that investigated the effectiveness of four Elementary Mental Health Operations (ELMHO) programs in Pinellas County, Florida. ELMHO programs were designed to provide school-based mental health services to children and their families to help elementary students with emotional disabilities learn to cope with their issues well enough to mainstream back into less restrictive academic settings. The programs addressed: (1) the child's behavioral problems and level of functioning through individual, group, and family counseling; (2) identified family programs through parent training and family counseling; and (3) consultation with teachers to help them develop problem solving strategies to work with these children. The evaluation of this program consisted of interviews with 62 parents, principals, social workers, and agency staff, school record reviews of participating students (n=369), 100 case record reviews, and 11 case studies. Results indicated participants stayed in the program longer than was originally intended, children with the most severe rather than mild to moderate disabilities were referred to the program, family involvement in the intervention was critical to significant progress, and more families/siblings needed to be involved. (CR)

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The Elementary Mental Health Operations Evaluation

Introduction

A 1986 Needs Assessment report conducted for the Juvenile Welfare Board (JWB), an independent special taxing district that funds delivery of children's services through other agencies, identified Pinellas County Florida as an area where children with emotional handicaps (EH) were undermet. In response, JWB began funding four Elementary Mental Health Operations (ELMHO) programs in Pinellas County. The purpose of the ELMHO programs was to provide school-based mental health services to the children and their families to help elementary students with emotional disabilities learn to cope with their issues well enough to mainstream back into less restrictive academic settings. The program's intentions were to demonstrate the effectiveness of intensive mental health intervention with this EH population with "mild to moderate" disabilities through improvements in behavior, increased mainstreaming, and decreased placement in more restrictive settings.

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Method

Subjects/Sites

There were four program sites; three of the sites involved students with emotional disabilities while the fourth site was moved within months of inception to a center for students with severe emotional disturbances (SED) as a result of the school system relocating the students.

Intervention/Program

The programs would address: (a) the child's behavioral problems and level of functioning through individual, group, and family counseling; (b) identified family problems through parent training and family counseling; and (c) consultation with teachers to help them develop problem solving strategies to work with these children.

The ELMHO program process was simple and straightforward. After a teacher referred the child, the therapist assessed the eligibility of that child. If parental permission was received, individual, group, and family counseling, case management, and psychiatric/psychological examinations were provided. The child could exit the program for reasons such as mainstreaming, "graduating" to middle school, leaving the school, or lack of progress. The program provided services in a natural setting, thought to be less threatening to families than agency-based mental health services.

Measurement

The evaluation of this program consisted of: (a) interviews including those with parents, school principals, social workers, program supervisors, agency directors, and JWB staff (N = 62); (b) school record reviews of all EH students at 3 target schools, a sample of SED students at the SED center, and all EH students at two non-ELMHO schools (N = 396); (c) case record reviews (N = 100); and (d) case studies (N = 11).

Results

Length of Stay

Participants stayed in the program longer than was originally intended. Evaluation data suggest that children with the most severe rather than mild to moderate disabilities were referred to the program. These children needed long term care beyond the prevention and early intervention components the ELMHO program was intended to provide. This excessive length of stay also reflected an apparent dependency on the program. Many ELMHO children reported not being ready to leave EH classrooms, and some reported that they intentionally misbehaved to stay. Parents expressed concern over what

misbehaved to stay. Parents expressed concern over what they would do when their children were promoted to middle school.

Parental Participation

The evaluation showed that involvement of the whole family in the interventions was critical to significant progress. If parents did not "buy into the program," then the child could be confused by the expressed wishes of the parents/family and the wishes of the program, limiting or preventing bonding among participants. It appeared that many of the families being served by the programs had a multitude of issues, making work with families difficult outside of the structured classroom setting.

Findings showed that more families/siblings needed to be involved in these programs. Service level numbers and comments by families indicated that children were often being served in isolation. Given the issues surrounding these families, nontraditional parent involvement strategies may need to be employed. It appears that the programs should also support development of community support services outside of mental health agencies so that families are able to independently seek additional help in the community.

Service Need

Accessing families through the school is a non-threatening way to reach individuals who might otherwise not seek help. There appeared to be a need for an increase in both the amount and types of mental health services available in this setting for children identified with an EH educational status. The level of services provided by the schools did not always meet the identified need of the child, because resources remain scarce within the school system.

School System Issues

According to the school system, there was no clear system in place to track students through the mainstreaming process. This made the development of some goals and objectives for ancillary programs, such as ELMHO, more difficult. As it currently operates, the goal of mainstreaming may not be a measurable, realistic objective for this program. Methods to recruit and serve children with less severe disabilities need to be developed, the desired outcomes need to be redefined, and/or a new approach to serving the intended target families needs to be considered.

Another issue is the need for trained teachers. According to the school district informants, there is a critical shortage of exceptional education teachers. Children can be negatively impacted by limited teacher training.

A final issue is that of appropriately ending services to children and families. The ELMHO program served the majority of the children with emotional handicaps in these four schools, making it difficult to close cases on children

four schools, making it difficult to close cases on children who have not left the classroom and/or school. The children may not understand why they no longer receive "special attention."

Service System Issues

Concern arises in regard to labeling young children with both mental health diagnoses and exceptional identification by the schools. Labeling can lead to self-fulfilling prophecies for failure in the client. By focusing on children with less severe levels of disability, labeling may be prevented.

Mental health agencies have begun to bill Medicaid, insurance, and/or families for the ELMHO services. Several concerns regarding this practice include: (a) the program was originally free to families and is still seen as such; (b) there is a need for a diagnosis/label to obtain reimbursement; and (c) the potential exists to have clients selected on the basis of income source, or to have treatment plans designed around what Medicaid/insurance will pay rather than on the needs of the client.

Carryover of clients from one year to the next was also found to be excessive and distorted true service levels due to a lag in record keeping. Cases closed during this program year at one site averaged 31 months from the last contact and the case being closed. Cases at other sites ranged from 5 months to 12 months between last contact and cases closing. Some of this lag was due to delaying paperwork until the slower summer months of the program.

The SED Center

The SED Center did not appear to be an appropriate site for the ELMHO program, for a number of reasons:

- Documentation (i.e., medical history, lost records, etc.) required by the program was consistently deficient.
- These children had more severe impairments than the population that the program model was designed to serve. The center had a very structured environment; the center's point and level systems did not provide teachers the flexibility to adequately accommodate individualized treatment goals. Children were required to complete two transitions before going back to their regular school, making this process long and difficult for these children.
- Most of the children in the SED program were Medicaid eligible. As before mentioned, there are concerns surrounding utilization of Medicaid-driven rather than client-driven admission and service levels.

Discussion

The original intent of the ELMHO program was to provide prevention and early intervention for children newly diagnosed as having emotional disabilities to help stabilize and mainstream them back into regular education classes. It slowly evolved into a program which appeared to serve children with the most severe problems, providing stabilization for them until they "graduate" to middle school. After leaving the program, the gains made while in the program appeared to be lost, and the children's problems continued to increase in severity. The "drift" between program intent and function clearly needs to be addressed. A beginning point might include the development of a problem solving team, including both representatives from JWB and the mental health agencies, with input from the school system.

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